

Testimony of Joel E. Streim, MD

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Mr. Chairman and Members of the Committee:

I am Joel Streim, president of the American Association for Geriatric Psychiatry. AAGP is dedicated to the mental health and well being of older Americans and the care of those with late-life mental disorders. AAGP's membership consists of 2,000 geriatric psychiatrists and other health professionals in clinical practice, education, and research.

AAGP appreciates this opportunity to testify before this Committee on the effect of age discrimination against older adults with mental disorders. My testimony will first address the impact of the problem. I will then speak to four specific areas that warrant the Committee's attention: the integration of mental health care and primary care, the translation of geriatric research into clinical practice, the quality of treatment for depression in late-life, and alcohol and substance abuse among older adults.

Impact of the Problem

Epidemiological studies have shown that more than 20 percent of Americans aged 65 years and older—approximately 7.5 million seniors—have a mental illness. As the population aged 65 and older is projected to double from the current 35 million to 70 million in the year 2030, the number of older adults with mental illness is expected to increase proportionately to 15 million persons. These disorders include dementia due to Alzheimer's disease and other neurodegenerative disorders, 30 to 40 percent of which are complicated by depression or psychosis, as well as mood disorders such as depression and bipolar illness, anxiety disorders, severe mental illness such as schizophrenia, and alcohol abuse.

We know that psychiatric illness in older persons is a public health problem, as accumulating evidence shows that mental illness is associated with worse health outcomes for elderly patients with co-occurring medical conditions, as well as higher health care costs. Research has shown that depressed older adults have worse clinical outcomes for a variety of conditions that are highly prevalent in late-life: hip fractures, heart attacks, and cancer. Depression increases mortality rates after heart attacks and among elderly residents of long term care facilities. In fact, depression is a stronger predictor of mortality among heart attack victims than a second heart attack. After surgical repair of hip fractures, depressed patients have poorer recovery rates during rehabilitative care compared to those who are not depressed. Among cancer patients, those who are depressed have worse pain control, increased hospitalization rates, poorer physical function, and poorer quality of life. Persons over age 65 have the highest suicide rate of any age group, and among those over 85, the rate is twice the national average.

Older adults with severe mental illness, a rapidly growing segment of the population, are falling through the cracks of an already stressed mental health system. Community mental health facilities often lack age-appropriate services and staff trained to address medical needs, which are almost always present among older adults who suffer from mental illness. Less than three percent of older adults receive outpatient mental health treatment by specialty mental health providers—and only one-third of older persons who live in the community and who need mental health services receive them. In fact, most older adults with mental illness receive their care from primary care practitioners and long term care facilities. Nursing homes are the primary providers of institution-based care for older persons with mental disorders, with 80 to 94 percent of nursing home residents having a diagnosable mental disorder. But studies have demonstrated that only a small percentage of them actually receive mental health services, with the oldest and most physically impaired residents being least likely to receive services. Older adults with mental disorders who receive their care from primary care practitioners often receive poor quality care—one in five of them is given an inappropriate prescription, they are less likely to be treated with psychotherapy, and they receive a lower quality of general health care, leading to excess disability and increased mortality.

Geriatric mental illness brings together two of the most damaging elements of discrimination in America: the stigma of advanced age and the stigma of mental illness. An old person in our society is often invisible, just because of advanced age. Worse than being invisible, an old person suffering from depression or dementia is devalued and dismissed. The National Institute of Mental Health has disbanded its aging research branch and has actually reduced funding levels in the area of geriatric psychiatry, even while its budget has grown over the last several years. And this has taken place in the face of projected exponential growth in this segment of our population.

These twin discriminatory burdens are evident not only in a lack of research, but also in inadequate access to treatment and appropriate services. Mental health care services in our country are designed for young and middle-aged adults in good physical health, ignoring the unique needs of older adults who typically have concurrent medical conditions that complicate their care. Instead of a system that provides coordinated care to manage the complex interactions of psychiatric and medical conditions—and the multiple medications used to treat them—older adults are subject to a system of fragmented care that falls far short of what we should consider to be a minimum standard of care. Even Medicare—with its primary mission of funding health care for seniors—carries the bias against mental health care that afflicts the nation's health care system more generally. That is, most mental health services under Medicare require a 50 percent copayment as opposed to the 20 percent requirement for treatment of all other medical conditions. And that's not just an insurance carrier's coverage decision—it's the law.

Integration of Mental Health Care and Primary Care

The problems associated with the fact that most older adults receive their mental health care from primary care practitioners can be summed up with one stunning statistic: one-third of older adults who commit suicide have seen their primary care physician in the

week before completing suicide, and 70 percent have seen their doctors within the prior month. Because of the disconnect between primary care and mental health care, older adults seen by their primary care physicians are too often misdiagnosed or improperly treated, and they continue to suffer from depression and other mental illnesses that complicate their medical conditions and lead to excess physical disability.

Better tools for screening and diagnosis by primary care practitioners are absolutely critical for better mental health among seniors. A major obstacle to improved care for mental illness is the lack of training of primary care practitioners in identifying mental disorders in their geriatric patients, as well as the absence of mental health professionals working collaboratively, on-site in primary care settings.

There is important research now underway, with early findings demonstrating great promise for innovative approaches to delivery of mental health care in primary care settings for older adults. Specifically, it has been demonstrated that older adults are more likely to receive appropriate mental health care if there is a mental health professional—a psychiatric nurse or social worker—working and coordinating care within a primary care setting than if they are referred to a mental health specialist located outside the primary care setting. Multiple appointments with multiple providers in multiple settings add up to an unacceptable burden to persons for whom concurrent chronic illnesses, immobility and other physical disabilities, and limited transportation options are serious constraints. There is also less stigma associated with receiving psychiatric services when it is an integral part of general medical care. Preliminary results from other studies have shown significant improvements in treatment response rates for elderly patients who receive coordinated mental health care integrated within primary care sites, compared to those who receive “usual care.”

If every primary care clinic with a substantial geriatric patient population had a mental health professional to attend to the needs of these elderly patients, their access to mental health care and their treatment outcomes—and many other aspects of their care—would be improved.

For the last two years, Congress has appropriated \$5 million to the Substance Abuse and Mental Health Services Administration (SAMHSA) for mental health outreach and treatment for the elderly. Representative Patrick Kennedy has introduced the “Positive Aging Act,” which would build on that grant to provide authorization for projects that integrate mental health screening and treatment services at community health centers and other public or private nonprofit primary care clinics. It would also support geriatric mental health outreach teams in settings where seniors reside or where they receive social services, such as senior centers, adult day care programs, and assisted living facilities. This proposal, if enacted, would provide an important advance in assuring that elderly Americans actually receive the mental health services they need.

Translation of Research into Clinical Practice

The 1999 Surgeon General's Report on Mental Health and the 2001 Administration on Aging Report on Older Adults and Mental Health underscore both the prevalence of mental disorders in older persons and the evidence that research is developing effective treatments. Scientifically tested treatments are effective in relieving symptoms, improving function, and enhancing quality of life. These interventions reduce the need for costly hospitalizations and long-term care without simply shifting the burden to the family. However, there is a pronounced gap between the emergence of effective treatment and subsequent implementation by health care providers. This gap can be as long as 15 years. If we delay the provision of new treatments to the present four million Americans with dementia the way we delayed the treatment of depression, a generation of seniors will be prematurely admitted to nursing homes. The Surgeon General and Administration on Aging reports emphasize the need for translational and health services research to identify the most cost-effective interventions, as well as effective methods of care delivery.

Special attention needs to be paid to emerging findings from investigations of serious late-life mental disorders such as schizophrenia, bipolar disorder, and other psychotic illnesses. Despite the fact that these conditions take a major toll on elderly patients and their families, clinical treatment often has not kept pace with scientific advances. Effective treatments are not getting to those who need it most. AAGP's members are at the forefront of research on Alzheimer's disease, depression, and psychosis among the elderly, and we believe that more science must be focused in these areas. But it is equally important to ensure that new medical knowledge is rapidly translated into clinical care. Improving the treatment of late-life mental health problems will benefit not only the elderly, but also their children, whose lives are often profoundly affected. Caregiving itself is an enormous drain on the financial security and health of family members, many of whom become depressed as a result. Research has clearly demonstrated the benefits of formal caregiver interventions and services, improving mental and physical health of family caregivers, and delaying nursing home placement of dependent family members. However, many caregivers still do not receive the mental health care and support that they need.

There is important research on geriatric mental health that could and should have life-altering effects in practice. But getting the information to practicing clinicians in a way that is useful to them and to their patients is an ongoing challenge in all areas of health care. For instance, new research has shown a strong correlation between chronic pain and major depression. Do practitioners know this? And how will they use it? Both pain and depression are underdiagnosed and undertreated in elderly patients. The pervasive attitude in society—and among many clinicians and patients themselves—is that getting old necessarily means living with pain and living with sadness. As such, many older adults mistakenly believe that being sad or having pain is an expected, normal part of aging, so they don't talk about it; instead, they accept it and suffer with it. Furthermore, they don't want to be stigmatized by others—or to perceive themselves—as weak or lazy. But we know that they are not weak or lazy; they are suffering from a

clinical illness. Symptoms of depression and pain, like symptoms of diabetes and Parkinson's disease, are treatable. And they deserve to be treated and relieved.

Quality of Depression Treatment

A colleague of mine describes the disparity in quality between follow-up treatment for geriatric depression and follow-up care for other medical illnesses this way: A patient comes to a physician with a fever, and the physician prescribes an antibiotic to treat the infection that is thought to be causing the fever. But the fever persists, and therefore diagnostic tests and changes in treatment continue until the cause is found and the appropriate treatment prescribed, and the symptom (the fever) is relieved as the underlying illness remits. He contrasts it with a story he was told by the director of nursing in a nursing home. Making rounds with her staff, the head of nursing remarked that Mrs. Jones seemed to be depressed. And the staff nurse responded that Mrs. Jones was being treated for her depression, and prepared to move on to the next patient. Unfortunately, in far too many instances of geriatric care, that's the end of the story. In this case, the head of nursing intervened, insisting that if the patient is being treated for depression and she's still depressed, then something's wrong with the treatment.

Over the past 15 years, the field of geriatric psychiatry has worked hard in the battle to increase public and professional awareness about late-life mental illness, conveying the message that depression is not a normal part of aging and that there are effective treatments available for depression in older adults. The battle is not yet won: there are still many unrecognized cases of depression in late-life. However, with the increasing availability of newer and safer antidepressant medications, more primary care physicians are initiating treatment in their older patients. Recognizing depression, making the diagnosis, and initiating treatment represents an incremental step toward improving the quality of care. But recent research has begun to reveal the next generation of problems related to the treatment of depression in older adults: poor quality of follow-up care. In nursing homes nationwide, more than one-third of patients now receive antidepressant medications; but half of these patients remain depressed. One-third are receiving doses less than the manufacturer's recommended minimum effective dose. Others might benefit from the addition of psychotherapy. Some may need more effective treatment for concurrent medical illnesses that complicate the course of their depression, or interfere with their response to treatment. In all of these scenarios, the current treatment is inadequate, and the quality of follow-up care must be questioned. When follow-up assessment indicates a lack of treatment response, principles of good clinical practice dictate that the treatment should be modified, with the goal of getting the patient better.

Ironically, a quality indicator introduced by CMS in 1999 to assess the quality of depression care in nursing homes only serves to perpetuate this problem. According to this indicator, when patients with depressive symptoms are receiving antidepressant drugs, the nursing home gets credit for delivering good quality care. Here we see the same flawed assumption that simply initiating treatment is sufficient, disregarding the fact that the presence of persistent symptoms is actually an indicator of treatment failure. Thus, CMS policy has unwittingly codified neglectful care in a regulatory indicator that

was intended to ensure quality of care. Neglect of the ongoing care needs of frail older adults, especially those in nursing homes, is too often the norm, both in clinical practice and in federal policy and regulations. We need to improve the quality of geriatric mental health care by translating scientific and clinical knowledge into health care policy and regulations, and put an end to warehousing misery in long-term care and other treatment settings.

Geriatric Alcohol and Substance Abuse

Earlier in my testimony, I spoke to the need for more targeted research in geriatric mental health. There are few areas where the knowledge base is more deficient and where there is a more serious dearth of research than in the area of alcohol and substance abuse in older adults. Is Grandfather quietly drinking himself to death or risking a fall with a disabling injury, and the consequent need for more care and a greatly reduced quality of life? How much is too much? Is it the reason for his memory difficulty? His unsteady gait? How does the alcohol affect his heart disease, and how much does it matter? Does he need treatment? What kind of treatment is available, and how can it be presented in a way that is acceptable to him?

Or, an elderly woman who lives alone is becoming more confused and neglecting her personal grooming and hygiene. Is this the early stage of a dementia? But there is reason to suspect that she is taking tranquilizers, and nobody is really paying attention to that. If she stops these drugs, will she get better? Who knows how much she's taking? She may be taking analgesics for arthritis, too, or antihistamines for her insomnia, and some of her symptoms may be related to drug-drug interactions. Her hypertension had been well controlled with prescription medication, but lately she forgets to take this. Will her medical condition worsen as a result?

There are few studies of substance abuse among older adults, but what we do know suggests the areas we need to explore. We know that the prevalence of alcohol dependence is not far from that of depression – the figure for “at risk” drinking is about 15 to 16 percent. And there is substantial alcohol abuse co-occurring with depression, an association that increases with advancing age. Due to neglect of research on late-life substance abuse, there is little data about the misuse of prescribed and over-the-counter medications, both of which may be major problems among older adults. We need research on abuse/misuse of all addicting substances in the elderly, including over-the-counter medications. We need comprehensive studies of what substances seniors utilize, who is utilizing what, and the impact of that use on mental and physical health, functional status, service utilization, and quality of life.

The standard definitions for alcohol abuse don't necessarily apply to older adults. A major question in the field is whether to base definitions on the amount of alcohol consumed or degree of functional impairment. For example, older adults who are consuming alcohol in significant amounts may not be driving or fighting in bars, making

them less likely to be identified as having a problem by the usual social or legal parameters that typically bring younger drinkers to attention. Alternatively, older adults may be consuming alcohol in quantities or patterns that don't normally suggest dependence. But falls may be a huge problem – and this “at risk” category doesn't even exist in current definitions. And the effect of alcohol consumption among the elderly is different in its impact on families. It may not be loss of work and income that is at stake, but rather the result of falls and consequent dependence on family caregivers. We also should look at the effect on younger generations in terms their own use or abuse of alcohol from the example that is set and assumptions that are made about acceptable consumption.

We especially need to pay attention to cohort effects. We need to know whether and to what degree the attitudes of aging baby boomers toward alcohol consumption and drug abuse may change the future incidence of addictive disease and alter the risk of developing other late-life mental health problems.

In the area of treatment, we need to identify age-appropriate services that can be effectively combined with therapy, including detoxification and prevention interventions. SAMHSA and the Department of Veterans Affairs have sponsored a major research effort to address co-occurring mental illness and substance abuse, and this is commendable. Preliminary findings show that elderly “at-risk” drinkers who have access to mental health care integrated in the primary care setting are twice as likely to see a mental health specialist, compared to those who are referred to a specialty facility, such as a drug and alcohol rehabilitation center. We also need geriatric research that examines the relationship of substance use problems and medical illnesses that commonly occur in older adults. Existing strategies for research and treatment of alcohol and substance abuse among younger adults do not adequately address the problem of comorbidity from medical illness seen in the geriatric population. This is yet another example of neglect of older adults and their unique needs, both in our national research agenda and in the design of clinical services for the treatment of alcohol and substance use disorders.

Conclusion

Treating mental illness among older persons presents a set of fascinating challenges—and we have the tools to succeed, both in research and clinical care. But if we fail to meet the challenges because of prejudiced beliefs and misconceptions about old age and mental illness, then we will have consigned our parents, ourselves, and our children to living the late stages of life unnecessarily beset by frailty, cognitive and emotional distress, and a concomitant loss of independence and quality of life. Mental disorders of late life are treatable; but ageist attitudes and health care policies that discriminate against older adults prevent them from getting the treatment they need and deserve. This is a shameful tragedy. It calls upon all of us to right the wrongs against so many older Americans.